

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10347

STATE FILE NUMBER

1003

2254

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2254

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital			Length of stay in lb 2 1/2		d. STREET ADDRESS (If outside, give location) 7529 So. Wharf		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arie Middle Paton Last Gunnells				4. DATE OF DEATH Month March Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan 4, 1897		9. AGE (In years last birthday) 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Winslow, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME G.R. Gunnells				14. MOTHER'S MAIDEN NAME Agnes Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Alice Caffey, 422 W. 8th, Claremore, Okla.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tubercular Congestion; DUE TO (b) Cardiac Hypertrophy; DUE TO (c) Fracture of Right Lung; PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exact time, place, and manner of injury could not be determined		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a. m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE 48	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 1030 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Patrick P. Taylor Coroner				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3.6.57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-6-57	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Claremore, Okla.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. MAR 6 '57		26. REGISTRAR'S SIGNATURE Earl Smith MS	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300
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securing the medical certification in the appropriate manner required by 195.140, Missouri Revised Statutes.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Missouri

x St. Louis

x St. Louis

x 1222 No. Ward

St. Louis City Hospital

March 5, 1927

Gunnelle

Patton

White

60 Jan. 1, 1927 x

White

White

W.S.

Andrew, Arkansas

Laborer

Anna Gibson

G.F. Gunnelle

Missouri State Board of Health, St. Louis, Mo.

Union

St. Louis

Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 365

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.